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ABSTRACT

Curriculum analysis of the English National Board for Nursing, Midwifery, and Health Visiting (ENB) critical care programs ENB 100, 124, 176/183, 199, and 415 revealed great diversity in programs bearing the same title. An evaluation identified if this diversity was reflected in the competencies acquired by students on different programs, students' learning experiences, or preparation of clinicians for the demands of current critical care practice. Data sources at five case study sites included interviews and observation to ascertain the clinical reality in which students undertook the practice component of the course. From these data, a set of competencies for each critical care course was generated. The findings indicate different stakeholders held different views on the definition of "effective education." Examples of the values-reality gap were illuminated. For example, in practice, a gap exists between espoused values of care delivery and the reality of care provision. Within the higher education institution sector, a gap exists where the values of learning and teaching have been engulfed by the quasi purchaser-provider split. Many clinical settings needed to reexamine how they achieved an effective clinical environment beside a quality learning environment. To ensure greater parity and equivalence of program outcomes through threshold standards, the following implications were identified: disparate student population; clinical experience; and practice assessment. (YLB)

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Research Highlights 49

Evaluation of the Effectiveness of Educational Preparation for Critical Care Nursing

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research HIGHLIGHTS

Evaluation of the effectiveness of educational preparation for critical care nursing

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Abstract

Curriculum analysis of the ENB 100; 124; 176/183; 199; and 415 revealed great diversity in programmes which bear the same title (Scholes, Endacott and Chellel, 1999). This evaluation intended to identify if this diversity was reflected in

- **the competencies acquired by students on different programmes;**
- **the learning experiences of the students;**
- **preparation of clinicians for the demands of current critical care practice.**

Five Case Study sites were identified. Data sources included: interviews with educationalists, clinicians, managers, students and purchasers from the associated Trusts; and observation to ascertain the clinical reality in which the students undertook the practice component of the course. From these data, a set of competencies for each critical care course was generated and sent out for national consultation. Copies of the core competencies can be obtained through the University of Brighton.

The findings summarised here highlight implications for the future provision of critical care education.

Main Findings

1) What is effective education?

Students defined the course as effective if:

- it enhanced their understanding of patients' conditions and/or relevant clinical activities;
- they learnt something new that enhanced their understanding of the speciality (e.g. the wider policy context);
- it enabled them to participate in the multi-professional health care team with greater confidence.

Educationalists held different views. 'Effectiveness' of a course meant that students underwent:

- a significant transition or awakening to their therapeutic potential as critical care practitioners; or
- an educational experience that would enable them to challenge the status quo, critically review their own practice and take measures to develop practice in the setting and/or assist in the development of others (subsequent ENB students or pre-registration students).
- a supernumerary period and were able to practice in units other than their work-base; or
- continued experience in their original work-base on the proviso they worked alongside a skilled supervisor who used the practice assessment tool to its full potential.

Managers' views were also varied. Polar constructs of what made a course effective included programmes that:

- enabled the acquisition of new skills whilst on the course or allowed for the consolidation of existing skills and the examination of research evidence to support those activities.
- minimally disrupted service provision or staffing levels. Conversely others felt that time for study leave and to practice in other localities was essential.

The achievement of a minimum number of staff who held the ENB award was frequently presented as a quality marker for the Unit and enhanced recruitment and retention to their area.

For some managers and educationalists the course was only effective because it was responsive to local need and rapid change. These stakeholders were more resistant to the notion of national threshold standards or core competencies because they feared this might inhibit local flexibility.

There is an urgent need to refresh the expectations of all stakeholders with regards to the expected outcomes of post-registration education and to review the mechanisms set in place within any environment to maximise the potential of an episode of learning. Priority should be given to ensuring effective learning strategies over flexibility, choice and convenience.

2) The values–reality gap

The findings illuminated a number of examples of the values-reality gap. First in practice, between espoused values of care delivery and the reality of care provision; and secondly, within the HEI sector, where the values of learning and teaching have been engulfed by the quasi purchaser-provider split (Francis and Humphrey, 1998). Marketisation and managerialism (Traynor, 1999) have had a profound impact upon the construction of the value of the course and what made it effective.

There needs to be a culture shift away from collecting awards to developing an appropriate skill mix for the clinical setting. However, there also needs to be closer matching of the learner's needs, values and aspirations with those of service providers and workforce planners. This requires a clear evaluation of how a clinical course might contribute to that individual's practice development as well as the practice development needs of the service provider.

The current purchasing model has tended to distance Universities from involvement in student selection. This needs to change to enable students to be appropriately recruited and advised.

There needs to be clarity about the student role i.e. student status applies to learning in practice and not only attendance at college for formal taught sessions.

The lack of a clinical career ladder with clear educational pre-requisites means that there is no financial reward attached to achievement of clinical courses. This has clear implications for the future recruitment and retention of nurses.

3) The learning environment

Many clinical settings need to re-examine the way in which they achieve an effective *clinical* environment alongside a quality *learning* environment. Evaluation of practice learning and assessment opportunities should take place involving all the partners in the education process to propose effective strategies.

The provision of appropriate learning opportunities to enable students to achieve specific clinical competencies requires a period of supernumerary time and allocation of time for practice assessment for the assessor and assessee. This requires investment in resources and a re-focusing of learning and assessment as part of working life.

The development of Education Sister posts within the speciality could usefully be expanded to facilitate the development of all staff within a unit/department.

4) Achieving threshold standards

The national variability and fragmentation demonstrated through this study have the potential to increase with the loss of the ENB's involvement in the validation of clinical courses. This is a subject of discussion between the DH, QAA and Workforce Development Confederations. However, reduction in variability in the outcomes of a programme also relies on:

- defining for whom the course is designed
- ensuring a full range of experience is available in the practice setting to achieve the competencies and, where it is not, setting in place measures by which the student can achieve these competencies from a placement in another clinical setting (overcoming the **practice-competency gap**)
- ensuring greater parity and equivalence in assessment procedures
- defining the minimum time dedicated to various theoretical aspects of the programme, practice assessment and study time.

To ensure greater parity and equivalence of the outcomes of programmes of study through threshold standards the following implications have been identified:

a) The disparate student population

Students were registering on the course with between one month and up to twenty-four years experience in the speciality. However, there was an indication that the majority of students now entering these programmes were at an earlier stage in their career. To establish a common exit threshold logically requires threshold entry criteria. Therefore, it is recommended that programme content be designed for a student with 18 months experience in the speciality and who has undergone some form of induction or D grade competency package.

b) Clinical Experience while on the course

Variation in the experiences available to students has arisen when the patient profile differs considerably from one unit to the next, serviced by the same University. Employability post course was often linked to the students' practice base rather than the HEI because this reflected the breadth of clinical experience encountered by the learner. It is recommended that students should be allocated to placements for a minimum of six weeks to enable them to work with patients with complex needs and develop competencies to match the threshold standard of the course.

For the ENB 100 and ENB 415 courses, the student would have to manage patients requiring care at level 2 and level 3 as defined in Comprehensive Critical Care, DoH, 2000; and A Bridge to the Future, NHS Executive, 1997. Similarly students undertaking the ENB 124 and 199 courses should be placed in settings where a full range of experience can be gained. This may require a radical rethink regarding who undertakes these courses, or a rethink about the range of courses that are offered by the Universities which make up the critical care portfolio.

This would not preclude the development of other 'critical care courses' to suit the needs of people working in environments that do not normally meet this range of patient needs,

however, to avoid confusion it is recommended that those courses do not bear the same title. Variation in practice experience and competence attainment could be logged in a portfolio. The portfolio could have a more significant role in supporting claims of competence made by applicants to new posts.

c) Practice Assessment

The validity and reliability of practice assessment must be addressed. The data suggest that predicting competence is most likely to be achieved by the following measures:

- direct observation of practice accompanied by question and answer with written accounts to evidence learning rather than competence. Emphasis is placed on the need for direct observation of performance in practice to assure competence at the point of assessment
- re-visiting and building on existing competence through a lifelong learning model i.e. not assuming an individual's competence by their position or years of experience
- achieving objectivity and credibility in the assessment process through appropriate selection and training of assessors
- clarity of purpose in the assessment (particularly where non-nurses are used in the assessment process).

5) Core competencies/national threshold standards

The competencies were developed to incorporate the views of the participants that they should:

- be specific and the majority should focus on the practice of delivering patient care
- include explicit cues to enable the assessor to make a clear judgement about the student performance
- be written in plain English
- involve the direct observation of practice and some other medium by which the knowledge that informs that competence is evidenced
- be standard across the country but this does not exclude additional competency statements which can be added to reflect local needs/experiences
- set to a minimum standard - which does not preclude demonstration of more advanced performance
- focus on clinical rather than academic skills that include competencies related to roles and responsibilities and take into account local and national service configuration
- be considered independent of academic levels of practice
- ascertain that the practitioner is able to teach that competency to a more junior colleague or assume responsibility for managing a small group of patients under supervision
- be considered in the context of other major directives and policy statements about the professional conduct of nurses and other members of the health care team: e.g. the 10 key roles identified in the NHS plan, new joint training in communication skills and in NHS principles and organisation (NHS plan p86, July 2000) the academic and practitioner standards (QAA Consultation Document, January 2001)
- be subjected to a formal evaluation exercise when they are in use.

Two key contemporary debates regarding clinical practice in A&E and theatres are acknowledged by the research team:

- the appropriateness of labelling Accident & Emergency and Operating Department courses as *'critical care'*.
- the possibility of changes in the configuration of emergency services, dependent on work currently being undertaken by the Emergency Services National Patients Access Team (NPAT). It is emphasised that the A&E competencies presented reflect the data from the research study hence are pertinent to A&E nursing as it is currently organised.

Project Outline and Methods

The research was commissioned by the English National Board for Nursing, Midwifery and Health Visiting for two years, from October 1999 to September 2001. The study was undertaken in three phases.

Phase 1

Five institutions were identified which ran the following critical care programmes: ENB 100; 124; 176/183; 199 and 415. Each institution was sampled on the basis of the level at which they ran the programme, the type of practice assessment they deployed; and to ensure a geographical spread of institutions. In some cases we had to selectively sample ENB 415 courses. A range of stakeholders were interviewed including education managers, lecturers and students (n = 202) about their expectations, and experiences with the programme. A key question included what type of core competencies should be included to ensure a national threshold standard for the ENB numbered programmes.

Phase 2

Clinical environments linked to each of these institutions were visited. Data were gathered by interview and observation to

a) seek the views of a range of clinical stakeholders (including students, alumnae, assessors, clinical managers and purchasers of the courses, n = 199) about the course and the range of competencies students acquire whilst on the programme and

b) to observe and/or explore how practice assessment was deployed. Data were collated from 80 episodes of observation conducted in 47 Units linked to the Case Study HEIs.

Phase 3

The competencies were generated from analysis of these data along with a distillation of competencies and learning outcomes from the sampled institutions. They were sent to a number of diverse audiences who were invited to feedback their responses by completion of a questionnaire. In total, 297 stakeholders from education, practice and management responded. Participants were invited to indicate whether they felt that each competency was: essential, desirable, or not applicable. The responses are listed alongside the competency statement for each course and are available from the Centre of Nursing and Midwifery Research, University of Brighton.

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